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Chapter 11

'All die be die': obstacles to change in the face of HIV infection in Ghana

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Abstract

Following the detection of the first HIV/AIDS in Ghana, a number of programs were undertaken to create awareness of the disease and to generate behavioural change among the population. However, the expected behavioural changes have not occurred, especially among the most vulnerable groups such as those aged 20-29 years. A study was conducted among selected students in the Central Region of Ghana on a wide range of issues including attitudes to sexual behaviour, sexually transmitted diseases, HIV and condom use. Results indicate that socio-economic conditions influence people's attitude to life; in some cases the desire to survive was the main influence. About 80 per cent of the young people considered abstinence from sex as a protection against STDs, but some of them had been pressed to have sex and were not able to follow what they considered the right course of action. Some believe that people may contract HIV no matter what they do, if they are predestined to be infected. They think some people are going to die anyway, and it may not matter much what they die from. Attitudes to condoms were frequently negative. To achieve behavioural change in relation to HIV/AIDS, we need to redesign the strategies adopted so far.

'All die be die' is a statement that translates to 'every death is death', implying that each person is going to die and that the cause of death does not matter much. The phrase was used by a sixteen-year old sex worker who, when asked why she was in commercial sex in spite of the spread of HIV, said that she needed to survive and that she could die from anything, including AIDS. In her view dying from AIDS through commercial sex was not different from dying from any other disease, including hunger. Another sixteen-year old HIV-positive sex worker we followed for about six months continued in her occupation in spite of counselling and discussions about her situation. Such attitudes to death in the era of AIDS point to apparent misunderstanding or lack of motivation for behavioural change in the existing socio-economic circumstances.

Although these two examples may not reflect the general situation with a number of young people in Ghana, they helped to explain some of the observations made as part of our work on the study of the social dimensions of HIV/AIDS. Some of the responses from people suggested that HIV infection was one of the many things confronting people and, therefore, death from AIDS was not different from death from other conditions.

This chapter reports on a study among young people in the Central Region of Ghana and the apparent lack of behaviour change among young people in Ghana in spite of HIV/AIDS. The areas examined are their attitudes towards premarital sex, HIV/AIDS and contraception.

Context

One of the outcomes of the outbreak of HIV/AIDS is that societies have been forced to examine some of the perceptions, attitudes and practices that have been taken for granted, particularly those on sexual activity, reproductive health and gender relations (Caldwell *et al*. 1993; Ahlberg 1994; Mann and Tarantola 1996).

The over-representation of young people among diagnosed HIV-seropositive persons, especially in sub-Saharan Africa, has generated interest in the socialization process. Secondly, in spite of nearly two decades of information and education on HIV/AIDS, behaviour has not changed sufficiently to affect the level of infection in a number of countries.

This chapter draws on people's beliefs, attitudes, perceptions and reactions to events. People react to events or accept change within the context of their existing conditions: during periods of optimism, they tend to take positive decisions and actions while the reverse occurs during periods of pessimism, when they need to be motivated to rise above the prevailing conditions.

Secondly, the diffusion model informs the study. The process of providing education and information is based on the assumption that people will adapt their perceptions and behaviour in response to the available information. Inherent in the model is the fact that there are barriers to the diffusion of information as well as to the adoption of new ideas or behaviour. To achieve behavioural change, barriers will have to be overcome. Change can be resisted if the barriers have not been overcome, at either the individual or the societal level.

Adolescence is characterized by the development of ideas of self, experimentation including risk-taking, and belief in invulnerability (Mann and Tarantola 1996). Risk-taking at this stage is a product of the development of individual identity and the perception of invulnerability. The aim of education generally and IEC in particular is to create conditions for self-actualization and to provide directions for the development of positive attitudes and responses.

For sub-Saharan Africa, there is a general change in the situation of adolescents. First, there is the change in the socialization process from being based on family, both nuclear and extended, and society, to being based on school, church or mosque, and the media (Ahlberg 1994; Mann and Tarantola 1996; Awusabo-Asare and Anarfi 1999). There is also an emerging biological-social gap, particularly for females. In the last three to four decades, average age at menarche has declined from around 14 years to about 12.5 years (Ghana 1983, 1994). At the same time females are expected to be in school, develop their careers and marry at a later age. This is unlike the traditional system in which girls were married at menarche or after puberty rites. Now the longer gap between menarche and marriage can create conditions for sexual networking. In addition, education has increased the circle of interaction for both males and females; this was limited in the traditional system.

Study design

The data are from a study of students in the Central Region of Ghana. In the study, 1500 students were targeted but 1350 were interviewed in four levels of the educational system. These are the

junior secondary school (JSS), the senior secondary school (SSS), teachers' training college (TTC) and University. The JSS is the second tier of the basic educational program and the notional ages for pupils at that level are 12 to 14 years. Finishing JSS is the end of education for some students. Students who obtain high grades at the end of the JSS continue for another three years at the SSS level. From SSS students enter a TTC, a polytechnic or university, depending on performance and interest.

For the study the schools chosen were:

1. Seven Junior Secondary Schools (12-14 years): two boys' schools, two girls' schools, and three mixed schools.[1] These are localized institutions and most of the pupils live within walking distance of their school.
2. Four Senior Secondary Schools (15-17): one boys' school, one girls' school, and two mixed schools. These are both national and local in character. Two of the schools selected are among the best in the country and about 90 per cent of the students are from outside the Central Region.
3. Three Teachers' Training Colleges: one all-female and two mixed. These are national institutions, of which there are 35 in Ghana, three of them located in the region.
4. The university: two of the five universities in Ghana are located in the region. One was purposively selected.

The Junior Secondary and Senior Secondary Schools were grouped according to whether they were boys', girls' or mixed, and the required numbers were selected by random sampling. All three Teacher Training Colleges in the region were selected while one university was purposively selected out of the two in the region. Each institution was allocated a number of respondents. In the JSS, SSS and TTCs, which each cover three years, students were selected from stages 1-3 from school registers. In the University, students were selected by hall of residence.

Methods

The first phase involved the administration of questionnaires to students. The questionnaire involved ten modules covering background of respondent, background of parents, gender roles, self-assessment, communication, HIV/AIDS, reproductive tract infections, family planning, contraception and general issues. In the second stage, the results from the study were discussed with students in the participating schools;this involved an open forum in the school with both the students who took part and those who did not take part in the study. Finally, two students and one teacher were invited to the University of Cape Coast from four of the participating schools for discussion to clarify some issues and to develop follow-up activities. The results reported here are mainly from the questionnaire and the discussions held in the schools.

[1] Originally four mixed schools were targeted but one had to be dropped in the course of the study.

Results

Perception of risk of HIV and pregnancy

The students were asked to evaluate themselves for risk of HIV infection and getting pregnant or making a girl pregnant in the next month, next year and the next two years. Over 80 per cent of the respondents did not consider themselves to be at risk of HIV infection or from pregnancy in the next month or next year.

Among the reasons for not being at risk of HIV infection are: not being sexually active or being a virgin and hoping to remain so, being a student, and religion opposed to premarital sex (Table 1).

Table 1
Reasons for not being at risk of HIV – next month and next year (% of respondents)

Results	Next month	Next year
Virgin/not sexually active	33.1	10.8
Student	46.7	40.4
Religion against premarital sex	11.0	25.1
Other	9.2	23.7

Some of the reasons for not being at risk reflect the type of education on HIV/AIDS in Ghana. Education on this topic for young people has mainly emphasized abstinence. Although this is useful, some of them are not able to sustain it, especially when they are under pressure. There is also an emerging trend of Christian fundamentalism in our educational institutions which seems to influence responses to issues on sex and reproductive health. One result is that people do not confront issues but defer solutions to 'God'. This is one of the attitudes giving rise to the responses 'predestined to happen' or 'punishment or Act of God'.

Contraceptive use

Overall reported contraceptive use was 12.7 per cent; however, it was 38 per cent among the university students. The two methods reported were the condom and the pill; the highest use reported was of the condom by the university students (Table 2). This is a positive sign. However, the number reporting withdrawal, in the circumstances of HIV risk, indicates that some people are still prepared to take risks.[2]

[2] In one of the schools, a student mentioned preferring body-to-body contact to the 'rubber'.

Table 2
Reported methods of contraception (students 15+)

	Institution			
Type of Contraceptive	SSS	TTC	University	Total
Condom (n)	22	40	93	155
Pill (n)	4	4	22	30
Rhythm (n)	9	23	79	111
Withdrawal (n)	14	46	84	144
Abstinence (n)	18	26	81	125
% using modern contraceptives	4.3	22.0	38.0	12.7

Although the condom was the most reported modern method of contraception, a number of the students had negative views about people who carried condoms. Respondents were asked if a girl who carried a condom in her purse was a bad girl. Over 40 per cent agreed with the statement that a girl who carried a condom in her purse was not a good girl. The proportion, however, declined with level of education (Table 3). Furthermore, only 17 per cent of the JSS pupils and 14 per cent of the SSS students indicated that they could definitely purchase condoms.

Table 3
Attitude towards a girl who carries condom in purse (% of respondents)

Response to 'A girl who carries a condom in her purse is not a good girl'	**Institution**				
	JSS	**SSS**	**TTC**	**University**	**Total**
Agree	58.3	44.4	32.6	24.4	43.2
Disagree	26.4	34.9	51.7	60.1	39.3
Don't know	15.3	20.7	15.7	15.5	17.5
Total number	386	487	178	238	1289

One of the indicators for reinforcement of behaviour is the extent to which people are willing to discus issues with significant adults, siblings and peers. Respondents were asked if they could definitely discuss condom use with father, mother, siblings, peers and other people. Fifty-seven per cent said that they could discuss condoms with peers but only about 30 per cent said they could discuss them with their father, about 40 per cent with mother and 50 per cent with a sibling. The few who said they could discuss condoms with either their father or mother were mostly the University students. In general, the younger respondents were prepared to discuss things among themselves rather than with adults. Asked why not with their father, they indicated that fathers always looked stern when it came to issues of sexuality.

Sex before marriage

Students were asked to react to a number of questions on premarital sexual activity. They were asked if they agreed to the statement that there should be no sex before marriage for males and females.

Table 4
No sex before marriage all right (%)

	Responses from males				Responses from females			
	Agree	**Disagree**	**NS**	**No.**	**Agree**	**Disagree**	**NS**	**No.**
All right for females								
JSS	69.0	23.4	7.6	171	83.6	12.6	3.8	207
SSS	76.1	20.3	3.6	251	89.7	8.1	2.2	224
TTC	77.4	20.4	2.2	93	86.8	12.1	1.1	91
University	73.2	17.1	9.7	123	85.1	6.1	8.8	114
Total	73.8	20.6	5.6	638	86.5	9.7	3.8	636
All right for males								
JSS	70.8	22.8	6.4	177	83.1	12.1	4.8	207
SSS	75.6	20.8	3.6	250	85.3	10.7	4.0	225
TTC	75.2	22.6	2.2	93	85.7	13.2	1.1	91
University	74.0	17.9	8.1	123	81.7	7.0	11.3	115
Total	73.9	21.1	5.0	643	84.0	10.8	5.2	638

Over 80 per cent of the respondents agreed that there should be no sex before marriage for both males and females; 80.3 per cent responded that it should not be allowed for females, 79 per cent that it should not be allowed for males. Although the difference is small, the double standards on sexual activity begin to emerge among the group.

Students were asked about the prevailing views on premarital sex among their age mates. On that issue, 53 per cent indicated that among their age mates premarital sex was acceptable for boys, and 47 per cent for girls. In addition, 36.7 per cent of the males and 24 per cent of the females reported that premarital sex could be allowed for people who intended to marry; the male-female variation occurs among all the four categories of students (Table 5). The acceptance of premarital sex among people who intend to marry could be one of the conduits for HIV infection.

Table 5
Premarital sex all right for people intending to marry

	Males	**Females**
JSS	46.7	40.9
SSS	35.8	15.9
TTC	35.5	16.7
University	26.0	15.7
Total	36.7	24.1

Pressure to have sex

Respondents were asked if they had ever been pressed to have sex, and to indicate the person involved. The results indicated about 20 per cent of the females had been pressed at some time to have sex (Table 6).

Table 6
Pressure to have sex: yes and outcome

			Accepted willingly	Accepted under pressure	Refused	Other[a]
	No.	%	%	%	%	%
Boy/girl friend	415	31.5	23.4	18.8	56.6	1.2
School mate	211	16.5	15.0	12.8	70.5	1.8
Teacher	101	7.9	14.3	6.4	75.7	3.6
Relative	128	10.5	15.9	8.0	68.1	8.0
Neighbour	234	18.4	17.3	13.4	67.1	2.2

[a]Other includes still persisting; thinking about it/not yet decided; reported

Some young people were under pressure to have sex from a variety of people, among them teachers, schoolmates and friends. Among the least discussed sources of pressure are relatives and neighbours. But as pointed out by Mann and Tarantola (1996):

> … whether it drives them (the youth) from home or not, sexual victimization not only places them at immediate risk for (HIV/AIDS) infection, but also increases their future risk by affecting their psychosocial development with regards to sexual self-esteem, self-concept and overall adaptive functioning (Mann and Tarantola 1996:244).

Some of these experiences of the young people, especially with teachers and some of the older people around them, contribute to their scepticism about behavioural change.

Discussion and conclusion

HIV/AIDS infection has not been confronted forcibly enough to generate the needed behavioural change among young people and in the population generally. As pointed out by Ainsworth and Over (1994), the incidence of HIV/AIDS has gone down in areas where there has been the political will supported by a system willing to make changes.

The responses appear to indicate that there are a number of barriers to behavioural change that have not been removed at the levels of either the individual or the society. Among them are some of the traditional perceptions such as the acceptability of premarital sex among people who intend to marry. Some of the experiences of the young people, such as pressure by older people to have sex, also do not encourage behavioural change.

The reasons given by students for not being at risk are those that have been presented to them about HIV/AIDS; that is, the general motivation for education and career. It must be pointed out that the group is already highly motivated. They are among the few who continue to secondary schools and university, so education is already a motivating factor. Given the existing situation, it appears that it is life as usual. There are no other motivating factors to generate change, especially among those who are not in school.

During discussions with some of the respondents, it also emerged that the nature of the education and the mode of delivery on HIV/AIDS were not encouraging enough. For young people, education for behavioural change on an issue such as sexual activity should adopt the social influence approach (Baldo 1996). The approach in Ghana is through the use of messages on

radio and television and a few flyers and books. With such a passive approach, behaviour is not likely to change in the manner that is needed to change the spread of the epidemic in Ghana. To achieve an impact, the young people should be assisted to develop specific life skills to enable them to resist pressures for unwelcome and unprotected sex, otherwise, 'all die be die'.

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